Article 1. ELIGIBILITY, ENROLLMENT, DISENROLLMENT, AND COST-SHARING

Section 1.01 ***CHIP Eligibility.***

(a) *Generally.*

CHIP eligibility will be determined by the Administrative Contractor. The Administrative Contractor will enroll and disenroll eligible individuals into and out of CHIP. Parents or guardians enroll Members in a health plan.

(b) *Continuous ~~eligibility~~ coverage for first twelve months.*

~~**Note: This section is still under development to ensure consistency.**~~

A child who is CHIP-eligible will, for at least the first year of CHIP, have twelve months of continuous coverage. That coverage begins on the first day of the month following the child's enrollment into a health plan unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month.

(c) *Pregnant women and infants.*

~~**Note: This text will be inserted based on the amendment to the RFP dated August 26, 1999.**~~

Pregnant teens will continue to be CHIP-eligible for the duration of their pregnancy and through the later of the 2nd month following the month of the baby's birth or the expiration of the mother's original eligibility.

Infants are automatically enrolled in the mother's CHIP health plan at birth with CHIP eligibility and re-enrollment following the same timeframe as those of the mother.

The CONTRACTOR through electronic means or the providers through calls to the provider hotline will notify the administrative services contractor when a pregnancy is diagnosed. The administrative contractor will freeze the pregnant teen's eligibility expiration date after notification is received. After the baby is born, the eligibility expiration date is set at the end of the 2nd month following the month of the baby's birth or the original expiration date, whichever occurs later.

The administrative services contractor will receive regular electronic file transfers from the Bureau of Vital Statistics (BVS) at the Texas Department of Health. The transfers will identify babies born to CHIP-enrolled teens. The BVS data is based on information reported by hospitals. To further ensure the reliability of the data, families also will be encouraged to notify the administrative services contractor by phone or in writing when delivery of a baby to a CHIP-enrolled teen occurs.

When the administrative services contractor is notified of the delivery of a baby to a CHIP-enrolled teen, the contractor must unfreeze the teen's eligibility expiration. The administrative services contractor will automatically enroll babies born to CHIP-enrolled teens into the mother's CHIP health plan with an abbreviated eligibility period concurrent with the mother's.

Section 1.02 ***Enrollment.***

To enroll in the CONTRACTOR'S health plan, the member's permanent legal residence must be located within the CONTRACTOR'S service area..

HHSC makes no guarantees or representations to the CONTRACTOR regarding the number of eligible CHIP members who will ultimately be enrolled into the CONTRACTOR'S health plan.

The Administrative Contractor will electronically transmit to the CONTRACTOR new enrollee information, PCP selections, and change information applicable to active enrollees five business days prior to the first day of each month. This monthly transmittal date is defined as the "cut-off date." Twelve months of continuous coverage begins on the first day of the month following enrollment unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month. The CONTRACTOR must accept all persons who chose to enroll in the CONTRACTOR's health plan without regard to the member's health status or any other factor.

A CHIP member is enrolled in a selected health plan for twelve months. However, the CONTRACTOR must accommodate changes in health plan enrollment for exceptional reasons or good cause, which will be defined by HHSC. Enrollees may change health plans the first day of the month following the month in which the exceptional reason or good cause situation occurred, in accordance with the same cut-off processing timeframes applied to new enrollees.

Section 1.03 ***Retroactive enrollment.***

Any interpretation of membership eligibility and effective dates is made by the administrative contractor with administrative review by HHSC on appeal and may include retroactive membership and effective date determinations because of administrative error, reversed appeals or other administrative action. Unless one of the disenrollment situations in section _____ applies, retroactive enrollment is limited to a maximum of two months.

If an member is retroactively enrolled into the CONTRACTOR'S health plan due to a successful appeal of an erroneous denial, the CONTRACTOR is liable for that child's medical costs only to the extent that care would have been provided if CHIP enrollment had originally been granted.

Section 1.04 ***Re-enrollment.***

At the beginning of the tenth month of coverage, the administrative contractor will send a notice to the family outlining the next steps for renewal or continuation of coverage. The Administrative Contractor will also send a notice to the CONTRACTOR regarding its enrollees and to a community-based outreach organization providing follow-up assistance in the enrollees' areas. To promote continuity of care for children eligible for re-enrollment, the CONTRACTOR may facilitate re-enrollment through reminders to members and other appropriate means. Failure of the family to respond to the administrative contractor's renewal notice will result in disenrollment from the plan and from CHIP.

Section 1.05 ***Disenrollment due to loss of eligibility.***

For those enrollees who are disenrolled because they are no longer eligible for CHIP, the CONTRACTOR will receive from the Administrative Contractor notice informing the

CONTRACTOR that the enrollees' coverage will end on a particular date. Disenrollment due to loss of eligibility includes, but is not limited to:

"Aging-out" when a child turns nineteen;

Failure to re-enroll at the conclusion of the 12-month eligibility period;

Change in health insurance status, such as a child enrolling in an employer-sponsored health plan (effective the last day in the month in which change occurred, except that retroactivity is limited to a maximum of four months);

Failure to meet monthly cost-sharing obligation;

Death of a child (effective the last day in the month in which the child died, except that retroactivity is limited to a maximum of four months);

The child permanently moves out of the state (effective the last day in the month in which the move occurred, except that retroactivity is limited to a maximum of four months); and

Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP.

If a child is disenrolled from CHIP, the child loses his or her CHIP eligibility and must re-apply for a determination of CHIP eligibility in the future.

Section 1.06 ***Cost-Sharing.***

Health care providers within the CONTRACTOR'S network are responsible for collecting all enrollee copayments and deductibles. No co-payments apply, at any income level, to well-child or well-baby visits or immunizations.

Co-payments for families between 100% and 150% FPL are as follows:

$2 per office visit
$5 per emergency room visit
$1 per prescription valued up to and including $15; $2 per prescription valued at more than $15
An annual self-declared co-payment cap of $100 per family

Co-payments for families above 150% FPL and up to and including 185% FPL are as follows:

$5 per office visit
$25 per emergency room visit
$5 per generic prescription and $10 per brand-name prescription

Co-payments for families above 185% FPL are as follows:

$10 per office visit
$35 per emergency room visit
$5 per generic prescription and $10 per brand-name prescription

For families with incomes between 186% and 200% FPL, a per-family annual deductible of $200 for inpatient hospital services and $50 for outpatient hospital services will apply.

Federal law prohibits CHIP-eligible families from incurring aggregate cost sharing liabilities greater than 5% of their gross income during a calendar year. To comply with this provision and the $100 annual cap for families between 100% and 150% FPL, the CHIP administrative contractor must provide families with a simplified form to track their total CHIP-related expenditures to ensure that they do not exceed the 5 percent or $100 limit. When a family reports reaching its annual cap, the CHIP administrative contractor will issue a sticker for each covered child to be attached to the health plan ID cards. This sticker notifies providers to waive co-payments for the remainder of the year. The CHIP administrative contractor also must notify health plans of enrolled families who are no longer subject to cost sharing requirements to ensure the co-payment obligation is suspended.

Except for costs associated with unauthorized non-emergency services provided to a member by out-of-network providers, the co-payments and deductibles outlined in this section are the only amounts that a provider may collect from a CHIP-eligible family.

Federal law prohibits charging co-payments or deductibles to members of Native American Tribes. The Administrative Contractor will notify the CONTRACTOR of enrollees who are Native Americans and who are not subject to cost-sharing requirements. The CONTRACTOR is responsible for educating providers about the cost-sharing waiver for this population.